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THE DETECTION AND TREATMENT.

OF

INTRA-UTERINE POLYPI.

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EDINBURGH :

SUTHERLAND AND KNOX, GEORGE STREET.

M D C C C L.

[FROM THE MONTHLY JOURNAL OF MEDICAL SCIENCE, JANUARY 1850.]

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AFTER a polypus, or pediculated tumour, arising from any part of the interior of the uterus, has once passed downwards into the vagina, the diagnosis of the disease is, generally speaking, very easy, the operation for its removal comparatively simple, and the result of the treatment in the highest degree successful and satisfactory.

But before a uterine polypus has passed through the os uteri—in other words, as long as it is still intra-uterine, or shut up and contained within the uterine cavity—the disease has hitherto been usually regarded and described as entirely beyond the reach of legitimate diagnosis and treatment. “It very frequently happens,” observes Dupuytren, “that polypi concealed in the uterine cavity, inaccessible to our senses and instruments, give rise to severe symptoms, the true cause of which *cannot* be determined.”¹ “When polypi,” he again states, “are entirely included within the uterus, the rational symptoms afford room only for conjecture; and examination by the finger or speculum are both alike insufficient.”² “So long,” remarks Madame Boivin, “as the polypus is concealed within the uterus, all that can be ascertained is the increased size of that organ.”³ “If the polypus,” says Dr Ramsbotham, “be still included within the uterine cavity, and if the mouth of the organ be closely shut, it is impossible to reach it by the finger, and conse-

¹ Leçons Orales, vol. iii., p. 542.

² Ibid, p. 490.

³ Practical Treatise on Diseases of the Uterus. Heming's Translation, p. 200.

quently quite out of our power to ascertain its presence.”¹ “So long,” according to Mende, “as a polypus is enclosed in the uterine cavity, its diagnosis is scarcely possible.”² “True uterine polypi, while they remain enclosed in the uterine cavity, furnish,” observe Roche and Sanson, “none but equivocal symptoms, which may be confounded with those of pregnancy. These different symptoms may also depend on chronic inflammation of the womb; and it is often impossible to distinguish this affection from polypus. In the actual state of the science, there is but one case in which a certain diagnosis may be formed—viz., when the neck being effaced, and partly opened, it is possible to feel the rounded tumour within.”³

These, and other passages that might be cited, show that intra-uterine polypi are generally considered at the present day as placed beyond the pale of any certain means of detection, or any possible means of operative removal. And some of the older pathologists, indeed, would seem to have believed that there was no necessity for devising such means, inasmuch as, in their opinion, no danger was connected with the disease as long as the polypus remained intra-uterine. They held that the great source of prostration and peril attendant upon uterine polypi—namely, the hemorrhage or menorrhagia which accompanies them—is not liable to supervene, till the polypus has passed through the os uteri. Levret, for instance, was of opinion that, as long as a polypus remained within the uterine cavity, there was no accompanying hemorrhage, and that floodings appeared only after the tumour had left the uterine cavity.⁴

Several years ago, I saw, with Dr Alexander Wood, a case, the result of which was distressingly opposed to this doctrine.

CASE I.—The patient was about fifty-five years of age, and unmarried. She had been suffering long under severe menorrhagia. The face was pale and anæmic, and her health and strength broken down. On examining, per vaginam, the os uteri was found closed; but the uterus felt somewhat large and distended; and Dr Wood believing, with me, that the hemorrhagic drain which was present might be the result of an intra-uterine polypus, the mechanical dilatation of the uterine cavity was advised, but given up, in consequence of local treatment being objected to. In a few weeks the patient sunk, under the continuance of the hemorrhage. On opening the body, Dr Wood and I found the lower part of the cavity of the uterus distended by a polypus, of the size of a small plum, and attached to the back wall of the uterus by a narrow half-broken stalk. The lining membrane of the uterus was white and bloodless; but the polypus was red, from engorgement and effusion of blood in its tissues. Its structure was fibrous; and there was another small fibrous tumour imbedded in the walls of the uterus, near the uterine extremity of the right Fallopian tube. It had descended lower down than at the time we examined, so as to have already dilated the cavity of the cervix; and the os,

¹ Medical Gazette, vol. xvi., p. 406.

² Krankheiten des Weibes, p. 591.

³ Nouveaux Elémens de Pathol. Med. Chir., tom iii., p. 284.

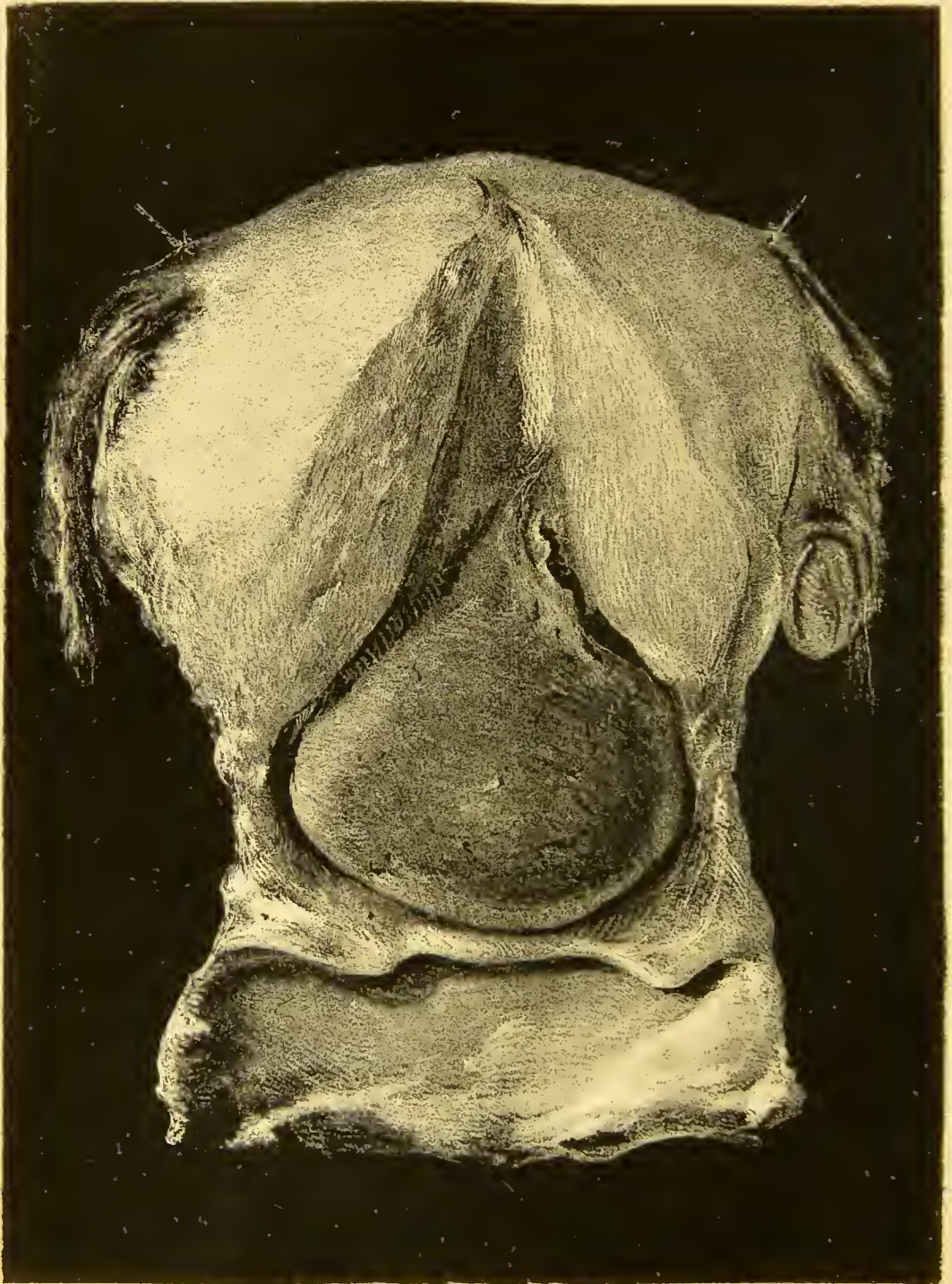
⁴ Levret—Sur la Cure Radicale de Plusieurs Polypes de la Matrice, p. 25, &c. &c.



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PLATE I



Drawn by a newly discovered method in lithography

By Schenck, M.D., Editor

Polypus fatal by continued hemorrhage while still included in the
uterine cavity

at the time of death, had begun to open. It was evident that, if the cavity of the os and cervix could have been artificially dilated during life, the polypus would have come within reach, and the patient's life been saved.—(See Plate I.)¹

I have seen several other cases of intra-uterine polypus, where the hemorrhage was both long in continuance and great in quantity. Some years ago, along with the late Dr Henderson, of Corstorphine, I excised a slender pendulous polypus, hanging from the os uteri, in a patient who, some time previously, had nearly died of excessive uterine hemorrhage of several days' duration, at Leamington; but at the period of that dangerous attack, the attendant physicians had been unable to discover any uterine organic disease, to account for the discharge. The polypus had not yet passed the os uteri.²

When nature, in cases of intra-uterine polypi, begins to expel the tumour, and open up the os uteri, we may, at that stage, as stated in a preceding quotation from the work of Roche and Sanson, find it possible to make a diagnosis of the disease by being able to "*feel* the rounded tumour within." If art could furnish us with any means of producing, at will, the same extent of opening of the os uteri, it would enable us in the same way to "*feel* the rounded tumour within" with our finger; and it is evident that, by this means, we would possess a power of detecting, with all the certainty of physical diagnosis, the existence or not of the disease within the cavity of the uterus, in cases in which the attendant rational symptoms—as the menorrhagia, uterine leucorrhœa, and perhaps the swelled state of the neck or body of the uterus—might lead us to conjecture the probable presence of an intra-uterine polypus.

In 1844, in a communication³ laid before the Medico-Chirurgical Society of Edinburgh, I proposed a means of safely opening up the cavity of the cervix and body of the uterus, to such an extent as might enable us to introduce a finger into the uterine cavity, for the purposes of diagnosis and operation in this and other diseased states of the organ. The means described consisted in the introduction of sponge-tents into the os and cavity of the uterus, so as gradually to dilate these parts to the degree required. For several years

¹ The uterus and its included polypus, from this patient, are in the University Museum; and Plate I. presents a faithful sketch of them, made from the preparation, and showing the size and site of the polypus, its place and mode of attachment, and the slight dilatation of the os that had taken place before death.

² In this, and in one or two other instances in which I have seen extreme degrees of flooding attendant upon small polypi, the narrow elongated polypus was of a cellular structure internally, and externally spotted and roughened over by numerous small linear-placed elevations, like those on the shell of the echinus.

³ "Mechanical Dilatation of the Cavity of the Os and Cervix of the Uterus, as a Means of Diagnosis and Treatment in some Affections of that Organ."—See abstract of it in the "Monthly Journal of Medical Science," 1844, p. 734.

past I have been constantly employing this means of dilatation of the uterine os and cavity, for a variety of purposes and indications. The sponge-tents used by myself and my professional brethren in Edinburgh, are manufactured by Duncan, Flockhart & Co. They are of a narrow conical or pyramidal form; and used of many different sizes and lengths, according to the object in view. One above the medium size is represented in Plate II., Figs. 2, 3, and 4. These tents are made by dipping a piece of sponge in a strong solution of gum-arabic—tying and compressing this sponge around a central wire, as its axis, into the required conical form, by a continuous layer of whip-cord, drying it thoroughly, removing the cord, and subsequently slightly coating the surface of the tent with tallow, or axunge and wax, to facilitate its introduction. The central wire passes only for half-an-inch or an inch into the base of the cone (see section of one in Plate II., Fig. 3); and the opening left by it serves as an aperture to transfix the tent with the tip of the metallic director (Figs. 1 and 4), used for guiding and introducing the tents through the os uteri. They are introduced like the uterine sound or the catheter; the handle of the metallic director, with the sponge affixed to it, is held and manipulated by the left hand, while the fore-finger of the right hand touches the os uteri, in order to guide and direct the apex of the tent into that opening. The old forms of sponge-tent used by surgeons, and made of sponge steeped in preparations of wax, required for their expansion and development the aid of heat, in order to dissolve their retaining ingredient. The tent I have described, made by steeping sponge in a solution of gum, requires moisture, and not heat, for the solution of its retaining material, and for the expansion of the sponge. Very generally the secretions of the surrounding mucous canal afford a sufficient quantity of moisture for these two purposes; but if not, a small quantity of tepid water may be injected from time to time into the vagina. Usually a well-made tent takes twenty or thirty hours to expand to its full extent in the os uteri; and dilates to four or five times the diameter it presented in its original compressed state. Generally the first tent opens up the os and cavity of the cervix, and allows the finger ample space to examine sufficiently its contents, and the state of its parietes. If it is necessary to open the uterine cavity higher, to enable the finger to pass into the cavity of the body of the organ, a succession of tents are usually required; and they must be passed completely through the os internum or narrow portion, lying between the cavity of the cervix and cavity of the body of the organ. The use of the tent for a day, generally, as I have already stated, dilates the os uteri and cavity of the cervix sufficiently; and the employment of the sponge is accompanied with little or no feeling of uneasiness. When it is necessary to examine the state and conditions of the interior of the cavity of the body of the organ, the persevering use of a series of larger and larger tents for several days

PLATE II.

Fig 1

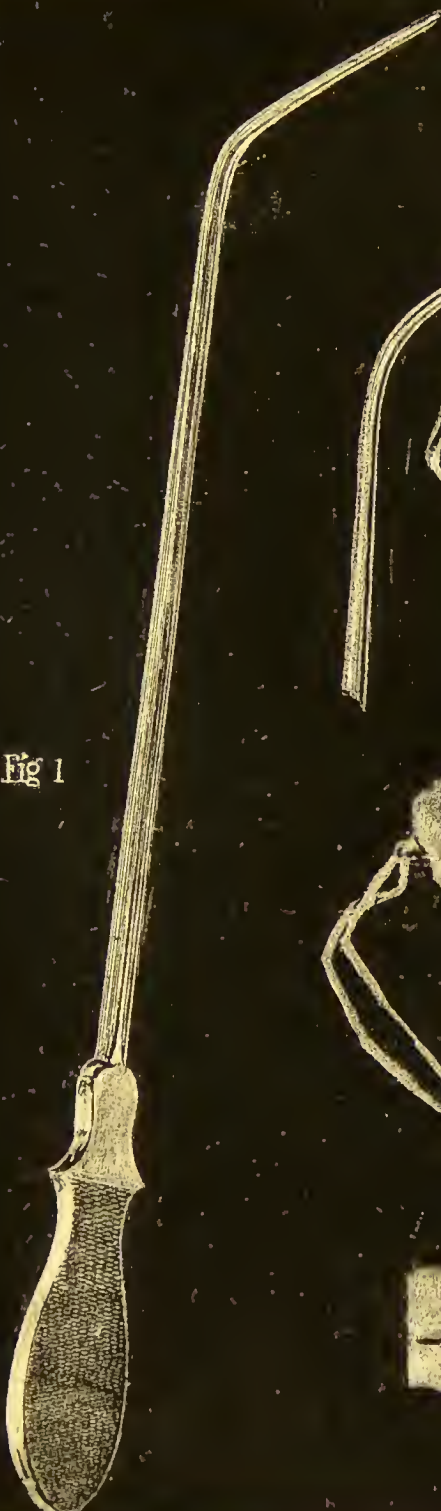


Fig 4



Fig 2



Fig 3





is usually requisite; and the dilatation of the os internum and body of the organ sometimes, but not always, causes a feeling of uneasiness and pain, that may require the use of an opiate. I have omitted to state that the tent is always prepared with a string affixed to its base, to allow of its easy removal.—(See Fig. 2 of Plate II.)¹ In using sponge-tents, it should be remembered that, when sponge is in contact with the maternal passages for some hours, it always exhales, when removed, a very foetid odour.

For dilatation of the unimpregnated os uteri, the tent should be selected as regularly conical as possible; and with the apex neither too blunt and rounded to pass the os, nor too slender and flexible so as to double back in the attempt. The spirally grooved surface of the tent, resulting from the compression of it by the whip-cord during its manufacture, tends to retain it *in situ*, till its expansion commences. It, perhaps, ought to be added, that the introduction of the sponge-tent into the os and cavity of the uterus, should be effected without the use of the speculum. The sense of touch serves, in this and some other analogous operations, infinitely better than the sense of sight.

By the use of sponge-tents introduced daily, and of increasing size and length, we may reach a polypus when affixed and sessile even upon the fundus uteri. One of the first cases in which I dilated the uterine cavity to its extreme height, was the following:—

CASE II.—In 1844, a patient, æt. thirty-six, under the care of Dr Graham of Dalkeith, had a miscarriage, from the effects of which she never satisfactorily recovered. Previously she had borne four children. When I first saw her, two or three years afterwards, she was emaciated and extremely pallid from the excessive loss of blood which she had been sustaining for some time; and her weakness was such, that it was with difficulty she could rise and walk across her bed-room. In August 1847, I dilated fully the interior of the cervix and body of the uterus by a succession of sponge-tents, and at last felt a hard round fibrous polypus seated at the very fundus of the uterus, and projecting, of the size of a walnut, into the upper part of the cavity of the organ. Dr Ziegler, Dr Toogood of Torquay, and other professional friends, confirmed this diagnosis. It was impossible to ascertain how it was pediculated, or to operate upon the pedicle. We could only reach the round body of the tumour; and that I compressed strongly and repeatedly in the blades of a lithotomy forceps, with the view of breaking down its tissue, so as to destroy the vitality of the polypus. A purulent discharge followed, and three largish pieces of organised

¹ Plate II. represents sponge-tents, and the instrument for introducing them. Fig. 1 represents the strong metallic handle or director employed for the introduction of the tents. At the distance of nearly two inches from its point, it is bent at an obtuse angle. From this angle the instrument is made to taper to a blunt point. Fig. 2 represents a sponge-tent of pretty large size, with the string for its extraction attached to its base. Fig. 3 shows a section of the tent with the linear cavity in its base intended to receive the point of the metallic director, as is represented in Fig. 4. Tents considerably smaller than those figured in this Plate are often required to be first used, especially if the os uteri is very small.

structure were subsequently cast off. Her recovery of health, after these discharges ceased, was gradual but perfect. There has been no return of menorrhagia. About a year ago she called upon me, and the change from excessive pallor and emaciation of the face, to the hue and ruddiness of health, was so great, that I had difficulty in being convinced of the identity of my former patient.

The *Symptoms* which might, *a priori*, induce a practitioner to conjecture the probable existence of an intra-uterine polypus, are, as we have seen in the quotations I have already given (p. 3), of a very uncertain and equivocal character. The polypus, while still included within the uterus, is principally liable to give rise to the following groups of symptoms:—

1st. Menorrhagia, in consequence of the discharge of blood from the surface of the tumour. The attendant hemorrhages take place particularly at the menstrual periods, but are apt to recur also at other times; and the blood is sometimes fluid; sometimes coagulated; occasionally there is an almost constant red stained discharge. The effects of these repeated floodings upon the constitution of the patient vary with their amount; but if they go on increasing (as they usually do) in quantity and frequency, the patient's constitution becomes gradually more and more shattered and broken down by the amount of hemorrhagic discharge; and all the symptoms of anemia in their most marked degree at last supervene, as pallor of the face and lips, great muscular debility, palpitation, vertigo, dyspepsia, œdema, &c.

2dly. The discharge of mucous, purulent, or serous matter from the cavity of the uterus, in consequence of the mucous membrane of the organ becoming often irritated, inflamed, and even ulcerated by the presence and pressure of the polypus. If a severe leucorrhœal discharge is present, and we ascertain by the speculum that it does *not* originate in ulceration or other morbid state of the external surface of the cervix, or of the vagina; and if we further detect, with the speculum, the discharge issuing from the cavity itself of the uterus, the probabilities of it originating in some pathological irritation within the uterus, will be necessarily increased. Sometimes the discharge, in cases of polypi, is fœtid, especially if it be retained, or mixed with decomposing blood.

3dly. Increased size of the cervix and body of the uterus in consequence of its interior being distended by the presence of the polypus, is traceable in those cases in which the polypus is of any great size. Not unfrequently intra-uterine, like vaginal polypi, are found combined with the presence of fibrous tumours in the walls of the uterus; and by these tumours the magnitude of the organ is increased, and its shape rendered more or less irregular. Fibrous tumours of the uterus are seldom or never situated in the walls of the cervix; and if the swelling and distension affect the cervix, there is consequently much more chance of its being a polypus and not an interstitial fibrous

tumour, than when we have similar symptoms attendant upon a similar augmented state of the body of the organ. Further, the probability of the disease being intra-uterine polypus would be increased, if, on successive examinations, we had an opportunity of ascertaining that the enlarged and distended state of the cervix was descending gradually lower and lower down towards the os; for polypi in their progress and descent (as seen in Case I. Plate I.) gradually dilate the cervix from above downwards in the same way as happens in pregnancy or abortion. They are born by a kind of chronic labour.

4thly. There may be symptoms of irritation and pressure upon the bladder, rectum, &c., if the polypus happen to be so large as to exert mechanical compression upon these or other parts, or dysmenorrhœa if it fills up the cavity of the cervix. And sympathetic pains may be present in the loins, limbs, &c.; or there may be sympathetic disturbance of the stomach, heart, &c., if the uterus is much irritated and excited by the presence and distension of the polypus.

But one or more of the preceding groups of symptoms may be altogether absent, though the uterus contain an intra-uterine polypus. The mechanical and sympathetic symptoms last alluded to are the most uncertain of all. For while almost all uterine diseases, however intrinsically different, give rise to similar secondary and sympathetic symptoms, we have often in other instances of the very same diseases, these same symptoms entirely wanting; just as in one woman during pregnancy we sometimes see severe, even serious, local, and constitutional symptoms; and in another woman, or even in the same woman in another pregnancy, we see the same condition of the uterus unattended by any special, local, or constitutional disturbance. Again, there may be no ascertainable increased volume of the uterus, as the polypus, especially if it is vesicular, and originates in the interior of the cervix, may be far too small to lead to any appreciable augmentation in the size of the organ, although, notwithstanding, the menorrhagia may be great; for the extent of flooding does not depend on the size of the polypus, small polypi like small hemorrhoidal excrescences, often being the source of severe and repeated hemorrhages. Further, the leucorrhœal discharge which is sometimes attendant, may be entirely absent, as the polypus may not be irritating the mucous surface of the cavity in which it is inclosed. And lastly, polypi occasionally, though not very frequently, are present for a long series of years without producing any degree of hemorrhage or menorrhagia. In the following case, for example, there was a state of long-standing amenorrhœa, instead of menorrhagia, co-existent with the presence of a polypus, though the two conditions (the amenorrhœa and polypus) had probably no causal relation to each other.

CASE III.—A poor woman, from East Lothian, aged about 35, and of a weak and debilitated frame, came, some three or four years ago, to ask for advice regarding the state of her health. She described her case as one of long-standing amenorrhœa. For five or six years the catamenia had been entirely absent; and

she ascribed her broken health to this cause. On examining the uterus and ovaries, in order to ascertain if there was any organic change to account for the amenorrhœa, I found, with the uterine bougie, the cavity of the os and cervix uteri very small, and the latter apparently obstructed, about three quarters of an inch from the orifice. I introduced a long thin sponge tent, with the view of determining more correctly the state of the cervical cavity. On removing the sponge, two days subsequently, I found the lower part of the cervix natural, but a flattened polypus, of the size of a small cherry, attached by a short pedicle to the interior of the higher portion of the cervical cavity. The pedicle was easily seized with a pair of long slender polypus forceps, and separated by torsion or avulsion. For some time subsequently to this little operation, menstruation recurred,—the irritation of the sponge tent having probably so far roused the uterus to a restoration of its secreting functions; but a patient, from the same neighbourhood, about half a year ago, informed me that her health had relapsed again into its former unsatisfactory state.

The polypus, in the preceding case, was intra-uterine. During the past autumn I removed a uterine polypus, which had long passed down into the vagina, and yet had never given rise to menorrhagia.

CASE IV.—The patient, 55 years of age, had, for at least twenty-five years, been aware of the occasional protrusion, between the labia, of a portion of what she supposed a fold of thickened and insensible skin. When she first noticed it, she had called the attention of her medical attendant to it, an eminent London obstetrician, under whose kind care she was for many years placed. He examined the tumour and its relations; but advised her to let it alone. Two or three years ago a little sanious discharge began to appear, and continued to recur almost daily. On examining the projecting body, I found it an elongated polypus, of the size and figure of the fruit of the date, and depending by a long slender stalk, which passed upwards through the os uteri. I divided the stalk with a pair of blunt-pointed scissors, immediately below the os uteri, and in four days afterwards the patient set off on a long journey. The polypus was of a dense cellular structure. At one point, near its fundus, its surface was ulcerated. The ulcer was of about the size of a sixpence, and, no doubt, the source of the discharge that had latterly appeared. Perhaps the removal of this polypus, when it was first discovered, would have enabled the patient to become a mother, and saved from extinction one of the highest and oldest titles in the kingdom.

Cases, however, like the above, of uterine polypi, of long duration, without attendant hemorrhage, are exceptions, and not very common exceptions, to the general rule. And certainly the existence and return of attacks of menorrhagia, draining and undermining the powers of the constitution—(without the presence of any ascertainable organic disease in the vagina, or around the os uteri, to account for the floodings, and the persistence of this discharge, in despite of all constitutional care and treatment)—forms always the most frequent and principal symptom that would induce the practitioner to use means to ascertain if there existed an intra-uterine polypus, or any other intra-uterine lesion, that was the probable source of the hemorrhage. He would, *a priori*, have more expectations of detecting, in his investigation, an intra-uterine polypus, provided, along with the menorrhagia, there was an occasional leucorrhœal or sanious discharge, coming—as proved by the speculum—from the cavity itself of the uterus, and not from the surface of the cervix; and provided, also,

there was an increased size or misshapen state of the cervix or body of the uterus, such as might result from the inclosure and distension of a polypus.

To convert, however, the probability derivable from such symptoms into a certainty, we must endeavour to read the true value of these rational symptoms by obtaining access to the cavity of the uterus itself, and ascertaining, by examination by the finger, if a polypus be present in that cavity or not, or if there be any other co-existent uterine lesion, capable of accounting for the symptoms. It is becoming every day more and more acknowledged, that we can alone discover uterine diseases, and discriminate them from each other, by appealing in this way to the evidence of physical diagnosis. And no remark could be, pathologically and practically speaking, more sound and true than that which Sir Charles Clarke many years ago made :—"The true character of any disease of the internal female organs can *only* be ascertained by examination."¹ With this view, in order to enable the finger to reach and examine the cavity of the uterus, the os and cervix must be opened up by a succession of sponge tents in the way already described. When an adequate degree of dilatation is obtained, the finger will be enabled to touch the tip of the polypus; and then the pediculated or polypous character of the tumour may be farther made out by passing either the finger or a uterine sound between its body and the containing cavity of the uterus. In making this examination, as in making most other examinations of the uterus, a rule requires to be followed which is too often forgot, namely to use both hands for the purpose. For if we are examining the uterus internally with the forefinger, or fingers of the right hand, the facility and precision of this examination will be found to be immensely promoted by placing the left hand externally over the hypogastric region, so as to enable us by it to steady, or depress, or otherwise operate upon the fundus uteri. The external hand greatly assists the operations of that which is introduced internally; and farther, we can generally measure, between them, the size, relations, &c., of the included uterus.

If without, or before, using sponge-tents, we are desirous to examine at the time when the os uteri is naturally most relaxed, we will find that time to be either immediately after a menstrual discharge, or immediately subsequent to any severe attack of intercurrent hemorrhage. Under such circumstances, we can sometimes introduce the finger partially into the os uteri, and ascertain the presence of any morbid body in the lower segment of the cervix; when in the same patient, at other times, this orifice is so completely shut as to prevent entirely such a proceeding. Sometimes, indeed, a small or elongated intra-uterine polypus will pass through the os uteri, at these times, so as to be felt by the usual vaginal examination; but will become retracted into the cavity of the cervix,

¹ Diseases of Females, vol. i. p. 250.

during the interval between the hemorrhagic discharges. In the following case¹ this occurrence was observed:—

CASE V.—About eight years ago, I occasionally saw a patient, who suffered much from leucorrhœa and menorrhagia. At last her health became so much broken in consequence of these discharges, and the pallor of the face and lips, and other symptoms of anæmia, so alarmed the patient, that she agreed reluctantly to submit to a vaginal examination. She had an objection, however, to me, on the score of youth; and the late Dr Beilby was so good as make the examination, and found a polypus, of the size of an almond, projecting from the lips of the os uteri. On Dr Beilby returning, two or three days subsequently, to put a ligature around the neck of the polypus, none could be found, and the os uteri was shut. The other symptoms, however, did not change; and, on the recurrence of a new hemorrhage, Dr Beilby made another examination, again found the polypus protruding, ligatured, and removed it.

In this instance, as in many others, the passage of the polypus through the os uteri did not produce any appreciable degree of pain. In enumerating the symptoms of intra-uterine polypus, I have omitted to state that, like polypi which have passed through the os uteri, they very rarely are attended with feelings of pain; and too often, both by the patient and the practitioner, the absence of pain is erroneously supposed to be a proof of the absence of organic disease. Sometimes, however, as they are pressing upon the lower part of the cervix and os uteri, or distending and passing through these parts, uterine contractions and pains temporarily supervene, similar to those of miscarriage; and, if there is any difficulty in the passage of the tumour, these pains may become exceedingly severe. In a case, in which a fibrous tumour of the uterus that had undergone the calcareous degeneration, and part of which had assumed a semi-pedunculated or polypous form, the recurrent pains, when the mass came down upon the os uteri, appeared at times as extreme as those of the last stage of labour.

CASE VI.—The patient, now sixty-nine years of age, the mother of several children, had for several years suffered from recurring slight attacks of uterine hemorrhage. In February 1848, I saw her with Dr Hunter. The os uteri was drawn up so high, that it was with great difficulty that I could reach and touch it; the top of the vagina stretched up in the form of an inverted funnel, the apex being placed at its upper or narrow extremity, and hence it was impossible to introduce or use a speculum. At the same time, the abdominal parietes were so thick and full, that it was impracticable to ascertain in any way the state of the uterus by an external examination. Not feeling a polypus, however, I left with the idea that the cause of the menorrhagia was some form of carcinomatous disease of the uterus. Subsequently, in the month of July, all her symptoms became aggravated, and very severe bearing-down pains were superadded. These pains recurred regularly once a day, lasted in paroxysms for several long hours, and always left the patient weakened and prostrated. In consequence of them, Dr Hunter made another examination of the vagina, and found the os uteri, which was now pressed lower down, filled with an apparently irregular bony mass. I saw her again, and removed the calcareous mass, filling up the os uteri, with a portion also of fibro-calcareous tumour, which we found above it, and distending the lower part of the cervix.

¹ See notice of an analogous case, by Dr Ramsbotham, in the Medical Gazette for 1835, p. 406.

The irregular calcareous portion protruded through the os uteri, was about the size of a hazel-nut, and the portion of fibro-calcareous tumour above it nearly four times that volume. The daily fearful pain which the patient had been lately enduring immediately ceased, and everything looked so favourable that we had every hope that the whole of the fibro-calcareous tumour, or polypus, had been removed. Last February, however, after some unusual exertion, the pains again recurred more severely, if possible, than before; and with this difference, that the attacks of them were now twice a day, instead of being only once, as on the first occasion. Opiates and sedatives had little or no effect towards their alleviation. On examining the os uteri, no new foreign body could be found anywhere within reach. As the patient's strength and spirits, however, were rapidly giving way, I dilated the os fully, by a succession of sponge-tents, and found the cavity of the cervix occupied by another fibro-calcareous mass, larger than the first. After an ineffectual attempt to break it down and remove it, by strong lithotomy and other forceps, I dilated the os still farther with tents, with the view of, if possible, getting two or three fingers up to seize the tumour, and assist in its detritus and extraction. To allow the hand to pass into the vagina with this view, I was obliged to incise its orifice; and, after no small difficulty, I was enabled to break off, by the fingers and forceps, four or five fibro-calcareous pieces from the mass in the cervix; and these pieces, when afterwards conjoined together, were found to form a roundish semi-pedicated tumour, of the size of an orange. In order to enable her to sustain the pain of these proceedings, the patient was kept, during this tedious operation, under the influence of chloroform. The pains again ceased from the date of the removal of this second intra-uterine tumour; and, under the kind care of her son, himself a physician, our patient made a good and steady recovery, and her health was restored by spending some of the autumn in the country. There still, however, remains in the uterine parietes some fibro-calcareous structure, as I lately ascertained by passing a uterine bougie into the elongated cavity of the uterus, and striking it against its hard stony surface.

The *Treatment* of Intra-uterine polypi requires to be varied according to different circumstances, but particularly by the tendency or probability of the tumour passing downwards or not through the os; by the effects of the symptoms or the urgency of the case; and by the size and site of the polypus.

Two plans of procedure may be followed according to the nature and necessities of the case, viz., first, to wait till the polypus descend farther; or, secondly, to remove it immediately. It is a generally acknowledged principle in obstetric surgery, that a polypus of the uterus should be extirpated as early after its discovery as possible.¹ But when such a tumour is discovered still included within the uterine cavity, and the polypus seems gradually but certainly making its way down-

¹ "In the treatment of this disease (uterine polypus) the first principle, undisputed, I suppose, by those who are possessed of experience in the management of these morbid growths, is, that it ought by all means to be extirpated; for unless it be removed, it will continue to grow larger and larger, till it utterly wears out life, and this especially if it be shooting from the upper part of the uterus, or even from the neck. It is, moreover, of vast importance in polypus, not only that it should be extirpated, but that this extirpation should be accomplished as early as possible. Lay this down, then, as a most important part of your practice, that polypi are not only to be taken away, but that they are to be extirpated early, as soon as they are discovered, and as soon as it is practicable."—*Blundell's Observations on Diseases of Women*, p. 126.

wards through the cervical cavity, and the hemorrhage and other symptoms are not urgent, it will assuredly be better to wait for its descent through the os; for after that its removal becomes much more easy and simple. The dilatation of the os and cervix by the sponge-tents will promote and facilitate its descent; and perhaps the internal use of the ergot of rye may aid it. But the degree of attendant hemorrhage and debility may be too great to entitle us to postpone the removal of the polypus; or the tumour may be attended by such a short pedicle as not to be capable of leaving the uterine cavity without dragging down with it, or inverting the fundus or some parts of the parietes of the uterus;¹ or it may be retained in its descent by adhesions formed between the surface of the uterus and the surface of the polypus. I once witnessed the dissection of a case of a large fibrous polypus included in the cavity of the uterus, and where inflammation had been present before death; the surface of the polypus was adherent to the surface of the uterus through the medium of a recently effused false membrane.² Even when an intra-uterine polypus has descended so far as even partially to open up the os uteri, it may remain in that situation for such a length of time, and with such results, as to place the patient in no small degree of danger. I shall quote, in illustration of this remark, an interesting case reported by Dr Meigs of Philadelphia, in his work on Female Diseases. Dr Meigs (p. 255), who quotes Dr Lee, to the effect, that "it would be folly to attempt the removal" of a polypus still retained in utero, details the case referred to in the following words:—

CASE VII.—Some months ago a lady came to me from New Jersey. She had been for some years labouring under a uterine disease, accompanied with violent and exhausting floodings. Upon arriving here, she was wholly unable to walk or sit up in her chair. I discovered a hard polypus, whose apex was lying just within the os uteri, which was a circular opening as large as a half dollar. The os uteri was pretty low down in the pelvis, it was very hard, and completely undilatable. The fundus uteri was half way up to the umbilicus, and the uterus hard and solid, so as to allow me to trace its outlines very clearly in my hypogastric palpation. I assure you I have rarely met with a more extreme case of anemia than in this person. This anemia was evinced not only in the pallor of her surface, and its flabbiness, and in her irregular breathing, the frequent palpitation of the heart, and the anemiæal throb of her pulses, but in the state of all her innervations, which were most miserable indeed, except when lying profoundly still in a low recumbency.

After a few days' refreshment from the journey, I attempted to do what I thought I should fail to do, namely, to get a ligature on the tumour. But I soon found how vain was such an attempt, for I never found the uterus a

¹ Cases of intra-uterine and vaginal polypi tending thus to invert the uterus at the site of their pedicles, are detailed by Denman (Introduction to Midwifery, p. 106); Davis (Obstetric Medicine, p. 618); Dr Oldham (Guy's Hospital Reports, New Series, vol. ii., p. 105); Scoutetten (Gazette Medicale for August 1839); Crosse (Transactions of Provincial Medical Association for 1845, p. 321), &c.

² Library of Medicine, vol. iv., p. 335.

moment relax, nor open beyond the size of a half dollar. My attempt caused an attack of hemorrhage to come on, that I was glad to suppress by cold, by rest, and by opium.

I kept her here many months, in hopes of seeing the uterus enter into powerful contractions to throw off the morbid mass. I gave her large doses of ergot. I thought the ergotism that was produced might expel the polypus, but I was disappointed, and subsequently had reason to believe the tumour had formed strong attachments to the inside of the uterine walls, so low down, that I could reach them with my finger, but could not break them up.¹

During her residence here, I thought to see her bleed to death before my eyes; her life was hardly saved by the tampon, so perverse was the hemorrhage. At length I sent her home, with directions as to her health, and a request to be informed if the tumour descended into the vagina. It will never descend into the vagina, if the adhesions I supposed to exist are truly there.—Dr Meigs on *Females and their Diseases*, p. 257. Philadelphia, 1848.

But, secondly, the severity of the attendant hemorrhages, or the improbabilities of the speedy and entire descent of the intra-uterine polypus, may induce us to remove the tumour at once; and certainly this may be effected in most cases, though with greater difficulties than in cases in which the polypus has passed down into the vagina. To admit at all of the removal of an intra-uterine polypus, of any considerable size, the os uteri must be previously very fully dilated by sponge-tents; and perhaps it will sometimes be found necessary, at the time of operating, to gain additional freedom, by dividing any obstructing band of the os or cervix that may not have been fully dilated by the tents. Afterwards, we will require to proceed differently in different cases, in order to destroy or remove the polypus. We may only be able to accomplish this object by contusing and crushing the tumour, as I have described in a case already detailed. (See Case II.) In the instance in question, I grasped the polypus, for this purpose, with strong lithotomy forceps. In another similar case, after fully dilating the os and cervix, I seized a large intra-uterine polypus between the jaws of a screw-propelled lithotripsy instrument—invented for the purpose of crushing vesical calculi—and was enabled, by it, to crush and destroy readily the structure and vitality of the included tumour. Occasionally, we may be enabled to divide the stalk of the polypus with a silver wire or ligature, acting on the principle of the chain-saw; or we may reach it with very curved blunt-pointed scissors. The two following cases may serve to illustrate these two last mentioned methods of operating:—

CASE VIII.—A patient, æt. 36, about three years ago began to suffer under menorrhagia and dysmenorrhea. The catamenia became both too frequent in their return, as well as much too great in quantity; but there was little or no leucorrhæal discharge. Latterly coagula of blood accompanied the menstrual periods, and the patient felt much weakened by each attack. The dysmenorrhea generally came on on the second day of menstruation, and confined the patient for a couple of days, the third day being usually one of much sickness

¹ The use of the uterine bougie would probably have determined this point; or the mechanical dilatation of the os by tents would have enabled the finger fully to reach and break the adhesions.

as well as pain, particularly if the patient tried to assume the erect posture. I first saw this lady in July of the present year, and found the uterus somewhat enlarged, and externally irregular in form, from the presence of one or two small fibrous tumours in its body and fundus. But the os uteri was shut, and I could not ascertain if the debilitating hemorrhage was the result merely of the irritation of these tumours in the parietes of the uterus; or whether one of them, forming a polypus in the cavity of the organ, was its source. I wrote her medical attendant to dilate the os in order to determine this point; and she returned home to England. In September she came back to Edinburgh; but, in consequence of the state of her health, I did not venture to dilate fully the os and uterine cavity till towards the end of October. On doing so, I was enabled to detect the rounded extremity of a polypus hanging down, into the cervical cavity. During two or three days it descended somewhat lower, but ultimately remained fixed and stationary above and within the os. I found I could not move it further downwards, by fixing a vulsellum into it, and applying some dragging force. On the 6th November, assisted by Dr Duncan, I applied a silver wire above the body, and around the neck of the tumour, by the instrument figured in Plate III. After the instrument was fixed and adjusted, a few turns of the screw made the wire cut through the pedicle of the polypus, and without any pain or suffering on the part of the patient. The separated tumour was then pulled, by the vulsellum, through the os uteri. The polypus was of the size and shape of a plum, with a small portion of the pedicle attached. It was fibrous in its internal structure. The patient's recovery was slow, but uninterrupted. She has menstruated once since the operation, but without the discharge being excessive, as formerly, either in quantity or duration (it lasted only three days); and also without her former distressing dysmenorrhœal pains.

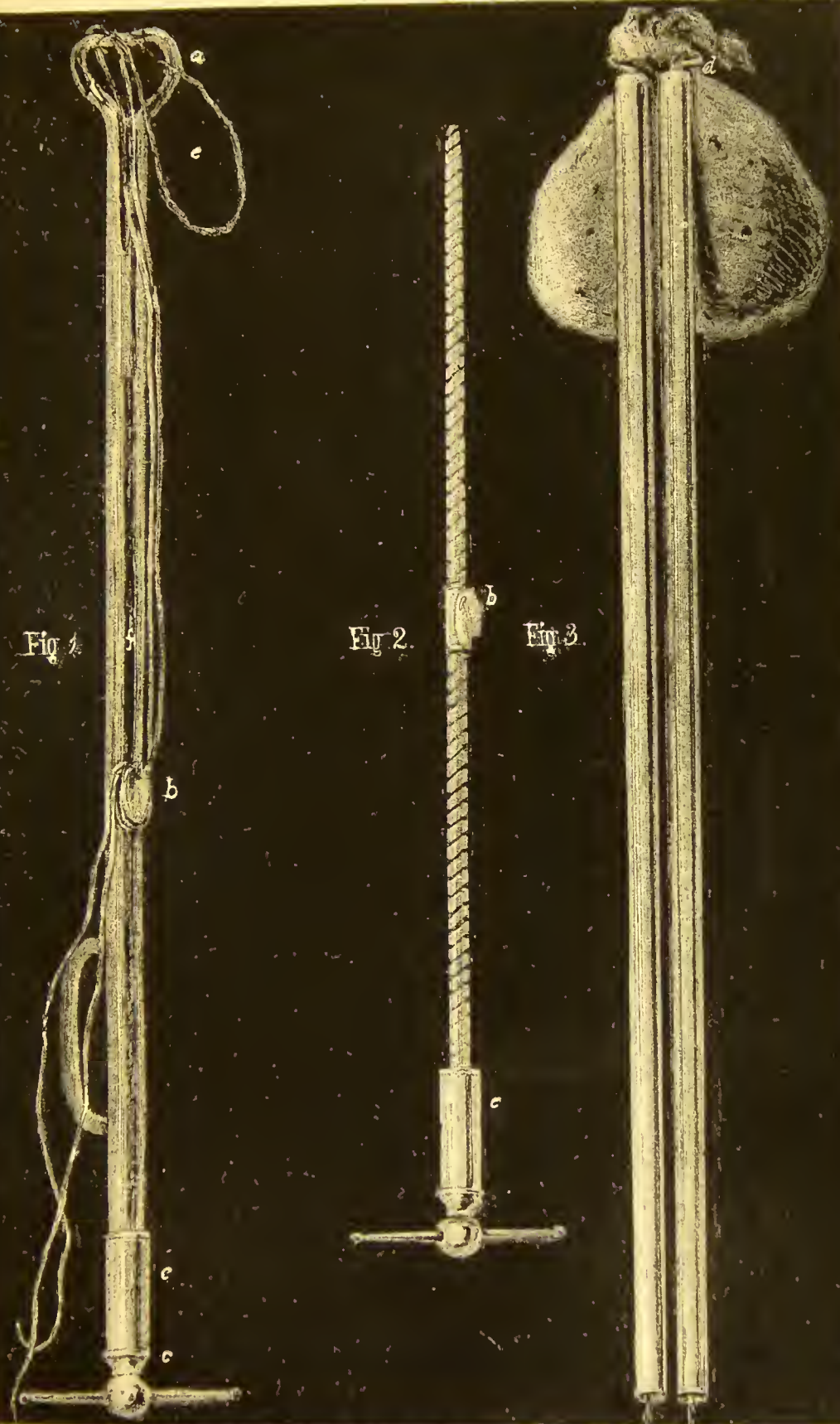
The instrument employed in the preceding case (See Plate III.),¹ is a modification of one kindly sent to me by my friend, Dr Sabine, of New York. I am told it has been successfully used by various American practitioners for the removal of polypi in the vagina. The advantage which it possesses over the instruments of Niessens, Gooch, Davis, and others, in the removal of intra-uterine polypi is, that the screw power with which it is furnished enables us to use it with the power of a small chain-saw, for the immediate division of the pedicles of the polypi. And it is almost superfluous to observe, that if we can finish our operation, it will be much safer for our patient than leaving a rough instrument within the cavity of the uterus. The instrument itself consists of two parts, viz., two hollow canulæ, like those pertaining to the instruments of Niessens and Gooch; and of a second part, resembling the polypus instrument of Graefe of Berlin, with this difference, that it has a ring

¹ Plate III. shows the instrument alluded to in the text, for seizing and dividing the pedicle of a polypus. Fig. 3 represents the two canulæ as they stand after their contained wires have been passed around the pedicle, *d* (Fig. 3), of a polypus. Fig. 1 shows the instrument used specially to divide the pedicle; *a* is the ring of the instrument, into which the canulæ are slipped, and which is run up along them to the pedicle (*d*); *c* is the noose of wire by which the pedicle is encircled; *b* is the knob or button on which the wires are twisted—it is made to descend along the linear slit *f*, by revolving the handle *c*. Fig. 2, shows the screw enclosed in the instrument (Fig. 1), with the handle *c*, and button *b*, in which it moves.

Fig 1.

Fig 2.

Fig 3.





affixed to its top, of a heart-shaped figure, and intended, first, to receive the two canulæ, with their contained ligatures, and afterwards to serve as a point of resistance during the cutting action of the ligature upon the pedicle of the tumour. The canulæ and ligatures (Fig. 3) are first applied in the same way, and according to the same rules, as those of Nicssens and Gooch. After the pedicle is encircled by the ligature, the two lower extremities of the canulæ and included ligatures are passed through the ring (*a*, Fig. 1) of the second portion of the instrument. This second portion of the instrument is then run up, with its ring surrounding the included canulæ, till it reaches the pedicle of the tumour; the projecting side of the ring being turned towards the pedicle. The canulæ are then slipped off, and withdrawn, leaving the wires or ligatures alone in the terminal ring of the instrument. Subsequently, these wires are twisted around, and fixed upon, the knob (*b*, Figs. 1 and 2) attached to the screw (Fig. 2). Lastly, by moving the knob downwards, by the operation of the screw, the ligature is made to cut into and through the pedicle.

In the following case, I was enabled to divide the pedicle of a large intra-uterine polypus with a pair of well-curved blunt-pointed scissors.

CASE IX.—The patient was aged 48, and unmarried. About 14 years ago, she was first seized, when in service, with a severe flooding. It returned at short intervals, and reduced her strength so much that she was obliged to leave her situation, and has never been able to take another. The hemorrhage she describes as having been almost constant for many years; that is, there was always some red oozing, and fluid blood and clots often escaped when she made any exertion. She had been treated by various medical gentlemen during this period, chiefly with iron, styptics, and astringents. A vaginal examination had never been made, in order to ascertain the source of the hemorrhage. During last autumn she presented herself for advice, at my house. She was blanched, thin, and debilitated, and scarcely able to walk. On examination per vaginam, the uterus felt enlarged, more particularly in its cervical region. A sponge-tent was introduced, and on her returning, two days afterwards, I found a polypus descended upon the distended os. Dr Ziegler, Mr Carmichael, and Dr Duncan, were present at the removal of the polypus. In order to reach, if possible, with the scissors, the pedicle of the polypus, I required to make a slight incision into the thin lips of the os. I was enabled at last, after some difficulty, and by seizing the polypus with a vulsellum on one of its sides, to turn the polypus laterally, and obtain access, with the scissors, to its pedicle, which was small and easily divided. After the polypus was completely separated, it took no inconsiderable amount of traction to drag it through the os uteri. The polypus was round, of the size of a small orange, and of a fibrous structure. The patient was rendered anæsthetic during the operation. The vagina was plugged with sponge, and the woman sent home. Next day the plug was removed. The patient has ever since kept free from any return of the flooding, and a degree of leucorrhœa, which followed, as often happens, the removal of polypi, is subsiding under the use of medicated pessaries. A month subsequent to the operation, she stated her strength to be greatly improved beyond what it had been for many years.

The preceding remarks, relative to the treatment of intra-uterine polypi, principally refer to these tumours when they happen to be of a

large size. But uterine polypi are often *too small* to be removed by the knife, scissors, or ligatures; and yet these small polypi not unfrequently lead to severe and long-continued menorrhagia. From the analogy of hemorrhoidal tumours, we know that the mere size of a polypus is not to be taken as any measure of its capability of producing hemorrhage. Small vesicular, mucous, or cellular polypi sometimes grow from the fundus uteri, giving rise to considerable and long-continued hemorrhagic discharge. I have preserved specimens of them from the dead subject, and have met with them in the living. They can hardly be properly termed polypi, as they are scarcely pediculated at their attachment, and sometimes short, but in other cases long and slender, in their body.

The following case may be cited as an illustration of this form of the disease:—

CASE X.—A lady, the mother of ten children, became irregular in her menstrual discharge during her 44th year. At times it was wanting at the usual monthly periods, at others it amounted to menorrhagia. About a year after this irregularity commenced, such an amount of fluid blood and coagula escaped as at first to lead on her part to some suspicion of miscarriage; but it continued to go on profusely for two or three weeks. At the end of that time, I visited her, with Mr B. Bell, and Dr Malcolm. On examining the uterus, we found a small vesicular polypus attached to the inner surface of one of the lips of the os, and it was easily removed by avulsion. The discharge, however, was not abated in consequence, as we expected. A series of sponge-tents was then introduced, so as to open up, first, the cavity of the cervix (which was found free from additional polypi), and ultimately the cavity of the body of the uterus. When the distension of the whole uterine cavity was at last completely effected, both Dr Malcolm and I found that we could touch two or three small slender polypoid bodies, hanging from the very fundus of the uterus. I removed them cautiously from the surface to which they were attached, with the nail of the first finger. After this the hemorrhage ceased, but some local treatment was required to cure the ulcerated state of the cervix. The polypi were removed in April. The patient went soon afterwards to spend the summer in the country, where she soon gained strength, and enjoyed much-improved health. I saw her lately. The menorrhagia had not recurred, but she still looked anemic, having never recovered her colour since the hemorrhages in spring.

Dr Malcolm informs me that, since meeting with the above case, he has seen another similar one, and treated it successfully in the same way. I may add, that in several cases of chronic and severe menorrhagia, in which I have been induced to open up the cavity of the uterus with sponge-tents, in order to ascertain whether there was any small intra-uterine polypus present or not, I have merely found the interior of the uterine cavity rough and granulated at particular points, which I have generally tried to remove and scratch off with the nail. Whether owing to their removal or not, or owing to the irritation resulting from the pressure and distension of the sponge, I know not, but certainly in two or three cases, the menorrhagia has subsequently abated and ceased.

By far, however, the most common site for the origin of small

vesicular polypi, is the interior of the cervix uteri. In fact, the small cellular or vesicular form of cervical polypus, is infinitely the most common form of polyposis disease of the uterus. Several specimens of them are represented in Plate IV. These cervical vesicular polypi are generally of a small size, like a pea, or orange pip, and vary from this to the size of a hazel nut. Sometimes they are sessile; and sometimes pediculated, as represented in the sketch from Cruveilhier. (Fig. 4). Occasionally they are single (Fig. 3), or they form a single complex cluster; but more frequently they are gregarious, as represented in Madame Boivin's drawing of them, copied in Fig. 1. Indeed it is, I believe, the rule rather than the exception to it, that when we find one (perhaps protruding at the os uteri, as in Fig. 12), we shall find, on further search, that there are others, sometimes to the number of four, five, or six, springing from other points of the interior of the cervix, and not discoverable till the cavity of the cervix is dilated by a sponge-tent. When hanging from the os uteri, their stalk is sometimes so loose and long, and the small depending polypus is itself so small and soft, that it moves away before the finger in making a tactile examination, and one unaccustomed to this peculiarity will not feel perfectly sure of the presence of such a polypus till the speculum is used, when the polypous body will be easily seen generally of a cherry-red, or purplish colour. Such polypi, though small, are often apparently the source of much menorrhagia and leucorrhœa, for they almost always co-exist with, and probably produce, some degree of ulcerative inflammation of the contiguous surface of the cervix¹.

In trying to remove these small vesicular polypi of the cervix, it is, therefore, to be held in recollection, that there are generally more than one present, and that to ascertain this point with any precision, it is necessary to dilate and expand the cavity of the cervix with a sponge-tent.

In more than one instance I have found these polypi (when their pedicles were perhaps long and easily broken) come away, imbedded in the surface and foramina of the sponge, which had torn them off during its expansion. But, in twenty-nine out of thirty cases, more methodic measures are required for their removal,—as scratching them off with a sharp nail, seizing and tearing them off with polypus forceps, or dividing their stalks with a pair of scissors. If we can

¹ A small cervical polypus may even produce death by the extent of hæmorrhage to which it gives rise. In an excellent practical paper on polypi, published by Dr Loecek, in the London Medico-Chirurgical Transactions for 1848, he states (p. 171), "Upwards of twenty years ago, the late Dr Robert Hooper showed me a preparation of a uterus, laid open, having a polypus not larger than a pea, with a short and narrow peduncle attached within the cervix, high up, considerably within the os uteri, and not perceptible till the cervix was slit open. All the history which he could give me was, that the uterus was removed from the body of a young woman, who had died in the Marylebone Infirmary, from long-continued uterine hæmorrhage."

use the speculum, these modes of removal are greatly facilitated by the sense of sight. Indeed, if we require to use the polypus forceps or scissors, for the removal of these small polypi, and guided by touch alone, we will generally find the operation, though apparently simple in principle, one which is tedious and difficult to perform in practice.

In a considerable number of instances of obstinate slight menorrhagia and leucorrhœa, I have been enabled to detect the presence of vesicular polypi attached to the interior of the walls of the cervix uteri, by opening up the cavity of the os and cervix with sponge-tents, and have afterwards removed them by the methods alluded to. The following was one of the first instances in which I pursued this practice:—

CASE XI.—A lady was confined of a premature child in early married life, and afterwards her health remained broken and wretched. She did not again conceive; and was unable to take walking exercise. There was a constant feeling of dragging and pressure about the pelvis. Betimes menorrhagia, and some degree of leucorrhœa, supervened. She was seen by many medical men in different parts of Europe. It was generally considered that there was a tumour on the back wall of the uterus; and for some years previous to my first seeing her, in 1842, she had been undergoing a course of local leeching, and other treatment, under the idea that the enlargement of the uterus was hypertrophic, and that her irregular menstruation was the result of congestion. I found the apparent tumour or hypertrophy of the uterus was formed by a complete retroversion of the organ. The cervix uteri was ulcerated, and I thought I could touch a small vesicular polypus, on pressing my finger against the os. I distended the cervical cavity with a sponge-tent; and, on removing it next day, I was easily able to trace three or four small cystic polypi attached to the interior of the cervix. I removed them, by picking each individual polypus carefully off with small forceps. An amelioration in the irregular menstruation immediately followed; and other means were subsequently adopted for the treatment of the other complications.

The small vesicular polypi of the cervix have sometimes, as we have already seen, long pedicles.¹ Occasionally, however, we find, co-existing with these pediculated polypi, others that are non-pediculated or sessile; and, occasionally after the cervix is dilated, we find others not raised yet above the level of the general surface of the mucous membrane of the part, but feeling imbedded like shot or peas in or beneath that membrane. In other words, we find, in some cases, these vesicular polypi in all their stages of formation, from small shut cysts, up to pediculated vesicular tumours. When such is

¹ Plate IV. contains four drawings of polypi of the cervix uteri. In Fig 2 is seen, projecting from the os uteri, a pisiform cystic polypus. Fig. 1. shows the same uterus opened up, and three small cystic polypi on the walls of the cervix. These two figures are copied from Figs. 1 and 2, of Plate XVIII., of the work of Madame Boivin, "on Diseases of the Uterus." Fig. 3 is taken from a plate appended to a paper by Dr Lee, in the nineteenth volume of the "London Medico-Chirurgical Transactions." Fig. 4 is copied from Fig. I. of Plate VI. of Fasciculus XIII., in Cruveilhier's plates of Pathological Anatomy. It shows some small pediculated polypi of the cervix uteri. Here, as often happens, there was co-existent disease in the body and fundus of the uterus.

Fig. 1

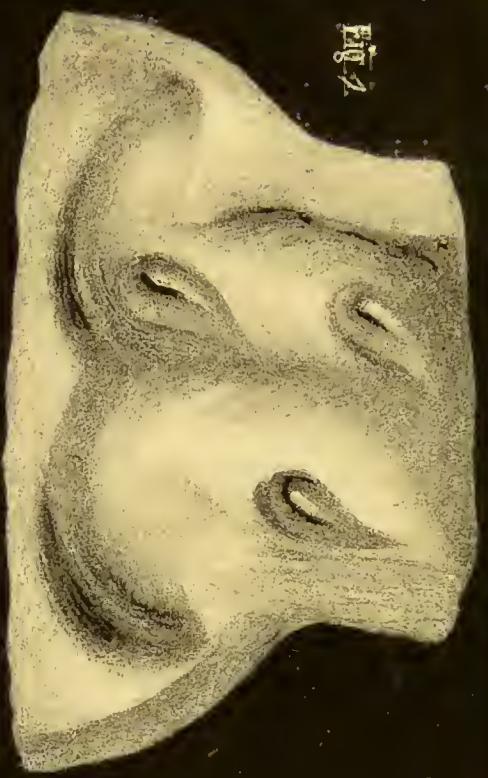


Fig. 2

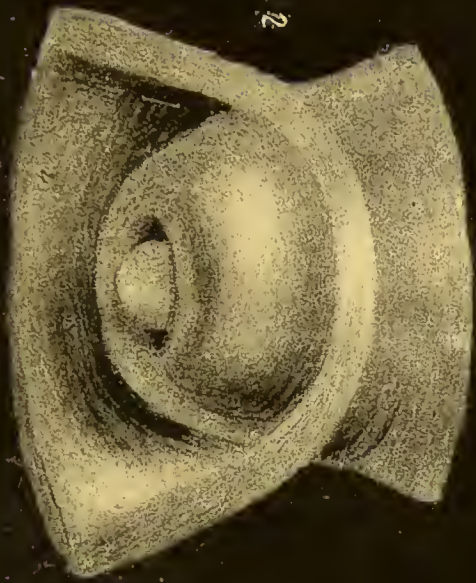


Fig. 3



Fig. 4





the state of matters, we can only remove those that are more fully formed, by the nails, scissors, or forceps. To effect a complete cure, we require other means; and for this purpose the application of caustics to the mucous membrane of the cervix answers every indication. Nitrate of silver generally proves too weak for this purpose, unless repeated very often, and combined with scarification of the mucous surface. We possess a far more potent and certain caustic for the purpose, and one that is perfectly manageable, in potassa fusa. The surface of the os and cervix, when small vesicular polypi exist, are often found to be the seat of chronic inflammatory ulceration; and sometimes the submucous tissue, and the structure of the cervix, is also the seat of chronic inflammatory hypertrophy and induration. When such a combination exists, the potassa fusa is doubly useful, as its application at once destroys the polypi, and sets up a new and healthy action in the affected and morbid tissues of the cervix. I have described, elsewhere, its great value and mode of application in inflammatory induration of the cervix,¹ and the power we have of immediately arresting and limiting its action by the neutralising effects of acetic acid. I need only add here, that I have now repeatedly found this caustic of the greatest possible use in obstinate and complicated cases of vesicular polypi of the cervix, such as I have above alluded to. In illustration of its effects, I shall cite only one instance, and that because it was a case which was peculiar in several respects.

CASE XII.—On the 1st October last, I was called into Roxburghshire, by Dr Anderson of Jedburgh, to see a lady who had been losing large quantities of blood for three weeks previously, and the hemorrhage had continued to go on profusely, day after day, in despite of all the means which he had tried for its suppression. The patient's strength had, in consequence, become greatly exhausted. She was between forty and fifty years of age; was the mother of a family, and for some years past had suffered under occasional menorrhagia. Three years ago, a uterine polypus had been detected at Brussels, and afterwards removed in London, apparently with some difficulty, as the first physician who attempted it, failed. Her present attack of hemorrhage was much more long-continued and severe than those that had occurred previously. Before being able to make a tactile examination of the uterus, I had to remove several large clots of blood lying in the vagina. I found the anterior lip of the os uteri very much enlarged, indurated, and roughened on the surface. By the speculum we saw this lip greatly enlarged, and dotted over with small pediculated red-coloured polypi like red currants; and the use of the mop showed them to be the source of the flooding. About a dozen of these small red polypi were within the field of the speculum, but others could be felt on the internal aspect of the enlarged lip. As it seemed hopeless to attempt to detach them all one after another by the forceps, and as doing so would not remove the suspiciously indurated and enlarged anterior lip of the cervix, I at once had recourse to the application of potassa fusa to the diseased lip itself, and melted it down, with the polypi attached, by decomposing upon it a couple of sticks of potassa, of above an inch in length each, and followed this immediately by the free and abundant injection of vinegar to neutralise

¹ Monthly Journal of Medical Science for 1847-8, p. 71.

the alkali. Subsequently, under the use of astringent injections and medicated pessaries, the surface took on a healthy cicatrisation, and her health greatly improved under Dr Anderson's kind and able care. I saw the patient in Edinburgh two months afterwards, on her way home to London. There were no remains of the induration or polypi. The uterus felt natural in size, and the surface of the cervix was entirely cicatrised. There has been no recurrence of the menorrhagia. The menses have been present once, but not in unnatural quantity.

